Name _____

NEIGHBORHOOD MEDICAL CENTER

WELCOME!

Dear Patient:

Welcome to Neighborhood Medical Center! All of us here at NMC –Doctors, nurses, front office staff, and administrators—will do our best to take care of your health care needs. But before we begin, we will need some information from you.

Please go through the rest of this packet and complete the forms as thoroughly as you can. If you have any questions, ask our staff.

When you are ready to register, we will need the following documents:

- **Proof of identification.** This can be a driver's license, a social security card, a birth certificate, or another form of photo ID.
- **Proof of Residency.** For example: a current driver's license, utility bill, property tax statement, or a voter's registration card.
- **Proof of Income.** For example: a check stub or a letter from your employer. If you have no income, you can bring in a letter stating, from whomever is giving you assistance.

If you do not have any of these items with you on your initial visit, you must bring these items with you to your follow-up visit in order to continue to receive services.

Please be in the office at least 20 minutes prior to all appointments. Patients arriving more than 10 minutes late will be rescheduled. If you need to cancel or re-schedule your appointment, please call us at 850-224-2469 at least 24 hours in advance.

Let our office staffers know if there are any problems during your visit, and please take the time to fill out our Patient Questionnaire to let us know how we are doing.

Thank you, and welcome to NMC!

Name _____

NEIGHBORHOOD MEDICAL CENTER

PEDIATRIC

PATIENT INFORMATION

PRIMARY LANGUAGE_____

TRANSLATOR REQUIRED? YES_____ NO_____

PATIENT'S
NAME_____
LAST FIRST MIDDLE INITIAL

S.S. No.:_____ RACE_____ D.O.B._____ AGE_____ SEX_____

PHONE_____ ALTERNATE PHONE _____ MARITAL STATUS_____

HIGHEST GRADE COMPLETED_____ EDUCATIONAL LEVEL_____ EMAIL:_____

PATIENT'S ADDRESS_____
STREET ADDRESS CITY STATE ZIP

ALTERNATE ADDRESS_____
MAILING / PO BOX CITY STATE ZIP

GUARANTOR INFORMATION: (IF DIFFERENT FROM PATIENT)

GUARANTOR'S NAME_____
LAST FIRST MIDDLE INITIAL

GUARANTOR D.O.B._____ GUARANTOR SOCIAL SECURITY NUMBER _____

RELATIONSHIP TO PATIENT _____

EMPLOYMENT: PATIENT OR GUARANTOR (CIRCLE ONE)

EMPLOYER'S NAME_____

ADDRESS_____PHONE_____

METHOD OF PAYMENT:

- ☐ CASH OR CHECK
- ☐ SLIDING FEE SCALE
- ☐ MEDICARE #_____
- ☐ MEDICAID #_____
- ☐ MEDICAL INSURANCE NAME AND ID #_____
- ☐ VISA/MASTERCARD/OTHER #_____
- ☐ OTHER_____

EMERGENCY CONTACT INFORMATION:

NAME_____
PHONE#:_____
ADDRESS:_____
RELATIONSHIP:_____

NAME:_____
PHONE#:_____
ADDRESS: _____
RELATIONSHIP:_____

Name _____

NEIGHBORHOOD MEDICAL CENTER

Financial and Insurance Policies

PLEASE INITIAL BELOW indicating that you have read, understands, and agrees to all the policies contained on this page.

_____ I grant permission for myself or minor child to undergo all necessary test, examinations, treatments, and other procedures required in the course of study, diagnosis, and treatment of illnesses by medical practitioners and other staff members of Neighborhood Medical Center.

_____I hereby authorize direct payment of medical benefits to Neighborhood Medical Center for services rendered by the physicians or the organization; I understand that I am responsible for any balances not covered by insurance claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.

_____Full payment for all co-pays, deductible and non-covered services are expected at the time of your appointment.

_____A returned check penalty fee of $25 will be charged to a patient's account for any check dishonored by the drawee bank. This fee will be waived if the check was returned in error, providing supporting documentation is submitted. The returned check and penalty fee must be paid by cash, credit card or money order. If a returned check was used to pay for more than one patient, each patient will be assessed the $25 returned check fee. Payments made by a returned check are reversed from the patient's account, leaving the balance due and payable immediately.

_____Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to your insurance carrier.

_____ I consent to the release of medical information to the patient's insurer or to authorized institutions or agencies that accept the patients for medical treatment and I furthermore give permission to release data (medical and personal) to such government agencies as required by Neighborhood Medical Center.

_____I certify that the information given by me in the applying for payment under title XVII of the Social Security act is correct. I authorize any holder of medical or other information about myself to release to the social security administration or the intermediaries of carrier's any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies, I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Name _____

NEIGHBORHOOD MEDICAL CENTER

Client Participation Agreement

CLIENT PARTICIPATION AGREEMENT

Applicant Name: _____ Social Security Number_____

This is to certify that the applicant listed may receive services from Neighborhood Medical Center from

_____ until _____.

Neighborhood Medical Center offers the following services:

Medical

Physical Exams, Screenings, Prescription Medication , Nutritional Counseling, Health Education, Eye Care Screenings, Mental Health Services, Well and Sick Care, Medical follow-ups, Case Management Services, and Health & Hygiene Items.

Dental

Extractions, Cleanings, Fillings, Sealants, and Limited Emergency Services.

These services have been explained to me. I certify that all information I have given regarding income and family size is true and correct to the best of my knowledge. I understand that although I or members of my family may be referred for specialty care, hospitalization, or other higher levels of care, there is no obligation for the provider to pay for these services. I understand that I am responsible for my dependents and myself. I will notify Neighborhood Medical Center when I cannot keep an appointment. Should I not utilize the services of Neighborhood Medical Center for a two year period; a letter will be sent advising me of the need to re-determine my eligibility. I understand that if I do not respond within two weeks, my name will be removed from the client list; this does not prevent me from re-enrolling as an active client in the future.

_____ _____

Patient's Signature Date

_____ _____

Witness's Signature Date

Name _____

NEIGHBORHOOD MEDICAL CENTER

Use And Disclosure Of Protected Health Information To Family Members And Others Who May Be Involved In Your Care.

Patient Name: _____ DOB: _____

As a patient of Neighborhood Medical Center, you may wish to authorize the disclosure of information related to your care to family members or other individuals. To protect your privacy while facilitating this communication, we will require you to list the name(s) of those individuals who are authorized to communicate with our caregivers and staff about results, appointments, findings, treatments, referrals and other inquires. In order to verify that the caller has the right to this information, our staff may ask some questions to verify the identity. However, such persons may be contacted if needed based on the professional judgment of our caregivers and staff. If you decline this disclosure, Neighborhood Medical Center will not answer to any inquiries from family members or other individuals.

_____**YES**, I want my protected health information disclosed to the following family members or other individuals.

_____**NO,** I do not want my protected health information disclosed to any of my family members or other individuals.

Name	Relationship to Patient
1.	
2.	
3.	
4.	

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Witness's Signature Date

Name _____

NEIGHBORHOOD MEDICAL CENTER

Parents' Authorization for Another to Bring Child(ren) to Care

We (I) _____ and _____

Parent(s) and legal guardian(s) of the following named children:

_____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

We (I) herby authorize any one of the following individuals:

_____ of _____

_____ of _____

_____ of _____

To consent to any and all medical care and attention for these children which is deemed necessary and appropriate by a physician licensed in the State of Florida. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. It also includes immunizations, if needed.

We (I) further agree to reimburse the health care provider for the cost of rendering these services. The children are covered under the following health plan:

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

Print _____ Date _____

Signature_____ Date_____